Addendum 4A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. If you have more than 20 affiliations in the past 5 years, you will only be required to verify the last 20 affiliations. Your signature below is your authority to release any and all information in your files, favorable or otherwise regarding yourself.

Name:_____M.D./D.O. _____
(Please print) (Signature)

Name and Address of Facility:_____

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To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith.

1. Position and Department of the above applicant?_____
2. Affiliation Dates: From _____To _____
3. Were any limitations imposed on this physician?_____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action._____
   _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action.
   _____
   _____
5. Was the above physician terminated from employment? _____ If yes, please explain in detail.

Derogatory Information, if any:_____

Comments, if any:_____

Signature, Date, Title _____

Printed Name _____

Facility _____

Affix Seal Here

Address _____

(If no seal, so indicate)

_____ _____

Phone Number _____